MIAMIBEACH

City of Miami Beach Group Health Enrollment Form

FOP Health Trust Participants

For Benefit Office use only
Grp #: Dental_____

Ben #: _____

Class/Division _____

General Information

Last Name | First Name | MI

Social Security Number ___ / ___ / ____ | City ID | Date of Birth (MM/DD/YYYY) __ / __ / ____ | Gender M F

Daytime Phone ___ - ___ - ____ Ext. | Evening Phone ___ - ___ - ____

Street Address | Apt/Suite/PO Box Number

City | State | Zip Code

Employment Status: ☐ I am an Active Employee ☐ I am a Retiree

Dental Plan – Please elect your coverage type and coverage level.

Coverage Type: ☐ MetLife DHMO ☐ MetLife PDP ☐ No Coverage

Coverage Level: ☐ Employee Only ☐ Employee + 1 ☐ Family

_____ _____

Employee Primary Dentist (MetLife DHMO plan only) | Dentist ID #

Are you a current patient? ☐ Yes ☐ No

Life Insurance –You may elect Supplemental Life Insurance from 1 to 5 times your annual pay. In addition, you may also elect life insurance for your spouse and/or your dependent children. Supplemental Life Insurance requests in excess of $250,000 may be subject to insurance carrier approval. Your Dependent Life Insurance election cannot be more than fifty percent (50%) of the employee's Supplemental Life Insurance election.

Supplemental Life Insurance - You may elect 1 times to 5 times your annual pay.

☐ 1x Annual Pay ☐ 2x Annual Pay ☐ 3x Annual Pay

☐ 4x Annual Pay ☐ 5x Annual Pay ☐ No Coverage

Dependent Life Insurance - You may elect coverage for your spouse and dependent children.

☐ $20,000 spouse/$10,000 child(ren) ☐ $30,000 spouse/$10,000 child(ren)

☐ $40,000 spouse/$10,000 child(ren) ☐ $50,000 spouse/$10,000 child(ren)

☐ No Coverage

Disability Insurance – You may elect Short-Term Disability and/or Long-Term Disability coverage. Your coverage and premium are based on your annual pay.

☐ **Short-Term Disability** - Replaces 60% of your weekly pay

☐ **Long-Term Disability** - Replaces 60% of your monthly pay

☐ No Coverage

Dependent Information – Please enter information for each dependent you wish to enroll for coverage. For additional dependents, copy and attach an additional dependent information form. **You must provide proof of dependency and the birthdates and Social Security number of each dependent. Dependents will not be enrolled if this information is missing**

1. Plan ☐ **Dental** ☐ **Dependent Life Insurance**

Last Name | First Name | MI

Social Security Number ___ - ___ - ____ Date of Birth (MMDDYYYY) __ / __ / ____ Relationship: Spouse ☐ Child ☐ Other ☐

Gender Female ☐ Male ☐

Within the past 12 months, has this dependent had any individual or other group coverage, including Medicare? Yes ☐ No ☐

Primary Dentist (MetLife DHMO plan only) Provider ID#

2. Plan ☐ **Dental** ☐ **Dependent Life Insurance**

Last Name | First Name | MI

Social Security Number ___ - ___ - ____ Date of Birth (MMDDYYYY) __ / __ / ____ Relationship: Spouse ☐ Child ☐ Other ☐

Gender Female ☐ Male ☐

Within the past 12 months, has this dependent had any individual or other group coverage, including Medicare? Yes ☐ No ☐

Primary Dentist (MetLife DHMO plan only) Provider ID#

3. Plan ☐ **Dental** ☐ **Dependent Life Insurance**

Last Name | First Name | MI

Social Security Number ___ - ___ - ____ Date of Birth (MMDDYYYY) __ / __ / ____ Relationship: Spouse ☐ Child ☐ Other ☐

Gender Female ☐ Male ☐

Within the past 12 months, has this dependent had any individual or other group coverage, including Medicare? Yes ☐ No ☐

Primary Dentist (MetLife DHMO plan only) Provider ID#

4. Plan ☐ **Dental** ☐ **Dependent Life Insurance**

Last Name | First Name | MI

Social Security Number ___ - ___ - ____ Date of Birth (MMDDYYYY) __ / __ / ____ Relationship: Spouse ☐ Child ☐ Other ☐

Gender Female ☐ Male ☐

Within the past 12 months, has this dependent had any individual or other group coverage, including Medicare? Yes ☐ No ☐

Primary Dentist (MetLIfe DHMO plan only) Provider ID#

5. Plan ☐ **Dental** ☐ **Dependent Life Insurance**

Last Name | First Name | MI

Social Security Number ___ - ___ - ____ Date of Birth (MMDDYYYY) __ / __ / ____ Relationship: Spouse ☐ Child ☐ Other ☐

Gender Female ☐ Male ☐

Within the past 12 months, has this dependent had any individual or other group coverage, including Medicare? Yes ☐ No ☐

Primary Dentist (MetLIfe DHMO plan only) Provider ID#

Prior Coverage This section must be completed if this is your first enrollment in the City of Miami Beach Group Health Plan.

Within the past 18 months, have you had any individual or other group dental coverage?

Dental Yes ☐ No ☐

If yes, please provide copy of your Certificate of Prior Coverage from your plan.

Compensation Reduction Agreement

I agree that my pay will be reduced by the amount of my required contribution for the benefit option(s) I have elected. The amount of my required bi-weekly contributions for each benefit option I have elected has been provided to me by Human Resources. I also understand the following:

- My premium contributions are taken from my payroll before taxes are calculated. I understand I cannot change or revoke this benefit election or compensation reduction agreement as of any date prior to the next Annual Open Enrollment, unless I have a qualified change in family status (qualified life event) such as the birth or adoption of a child, marriage, divorce, death of my spouse, a reduction in hours, or termination of my spouse's employment. Eligibility for Medicare for my spouse or me does not constitute a qualified life event. I will notify Employee Benefits within **30 days of the qualifying event** to make any necessary changes to my elected coverage. I also understand documentation will be required for verification.
- The establishment of and my subsequent participation in a union sponsored medical or dental plan during the plan year will not change my plan participation at that time.
- If my required contributions for my elected benefits are increased or decreased while this agreement remains in effect, my pay will automatically be adjusted to reflect the increase or decrease in premium.
- During the Annual Open Enrollment each year I will be provided the opportunity to change my benefit elections for the following Plan Year. If I do not complete and return an election form during that time, I will be treated as having elected to continue the benefit coverage then in effect and the associated required contributions, unless otherwise required by the City.
- The Plan Administrator may reduce or cancel the amount of my payroll contributions or otherwise modify this agreement if the Administrator believes it is advisable in order to satisfy provision or changes in the provisions of the Internal Revenue Code.
- I am responsible for the associated contributions for all the benefit coverage I elect, and understand my coverage elections may be terminated should my bi-weekly compensation be reduced to a level insufficient to cover the cost of my elected coverage.
- The reduction in my cash compensation under this agreement will be in addition to any other reduction under any other agreements or benefit plans.
- I understand that any misrepresentation of the eligibility of my dependents may result in my loss of eligibility under the City of Miami Beach Group Health Plan and may also result in disciplinary action up to and including termination of my employment.

Signature

Employee Signature	**Date**